DEPENDENT PERSONALITY DISORDER AND OTHER PERSONALITY DISORDERS: A CRITICAL INTRODUCTION

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INTRODUCTION

In the technical terms of psychiatry, mental illness covers mental disorders, personality disorders, and learning disabilities. The latter two are seen as distinct from the first. This monograph attempts to explore the many aspects of Personality Disorders (1) generally, and Dependent Personality Disorder specifically.

Parker (1988) feels that Personality Disorders have a "lost planet status" in that researchers are unsure how to classify or measure them. Defining personality disorders generally has been difficult.

Schneider (1923), for example, called them "abnormal personalities": "who suffer through their abnormalities and through whose abnormalities society suffers". Later Rado (1953) used: "Distress of psychodynamic integration that significantly affects the organism's adaptive life performance, and its attainment of utility and pleasure".

More formally, ICD-9 (WHO 1978) expanded the definition to:

> Deeply ingrained maladaptive patterns of behaviour generally recognisable by the time of adolescence or earlier and continuing throughout most of adult life, although often becoming less obvious in middle and old age. The personality is abnormal either in the balance of its components, their quality and expression, or in its total aspect.

And in DSM-IIIR (APA 1987): "Behaviour or traits that are characteristic of the individual's recent (past year) and long-term functioning (generally since adolescence or early adulthood). The constellation of types of behaviour or traits causes either significant impairment in social or occupational functioning, or subjective distress".

Subsequent definitions in ICD and DSM have moved closer together. Personality Disorders are defined in DSM-IV and ICD-10 as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture" (Farmer et al 2002 p153).

APA (2000) is more precise: "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts" (p685).

The sufferer is seen as differing in terms of:

a) Cognition - how they perceive and understand the world, events, and themselves;

b) Affectivity - emotional responses: in terms of the range, intensity, and appropriateness;

c) Interpersonal functioning - interactions with others;

d) Impulse control.

The individual will deviate from the norm in at least two of these areas, and that this behaviour is inflexible covering all situations of their lives over a long period with adolescent origins. The behaviour must also cause distress (APA 1994).

HISTORY OF PERSONALITY DISORDERS

The idea of enduring characteristics has existed since early Greek writings, though terms other than personality have been used, like temperament, constitution, habit, or character (Berrios 1993).

In the 19th century, diagnostic categories were created which began the attempt to distinguish personality problems from other mental problems. For example, "mania without delusions" ("manie sans delire") by Pinel in France or "moral insanity" coined by Prichard in England (Berrios 1993). But, in many cases, personality "disorder" at that time were seen as the result of failures in the "will" (Berrios 1993).

In terms of the current view on Personality Disorders, Kraeplin (1907) suggested that "personality disturbances" were a form of major psychoses, seeing them as a continuum. Whether Personality Disorders are different to mental disorders is still being debated today, and an alternative view comes from Jaspers (1927), who distinguished between personality developments and disease processes.

While Schneider (1923) distinguished between "abnormal personality", which deviates from the average, and "disordered personality", an extreme version of the normal personality. A subgroup of "abnormal personality" was called "psychopathic personalities", and had ten variants. It is the term and concept of psychopathic that has dominated Personality Disorders. Even if the meaning has changed over the twentieth century.

The forerunners of modern classification systems for mental disorders (eg: "Standard Classified Nomenclature

of Disease" 1932) and the early versions of the current systems implicitly used personality disorder terminology and concepts.

DSM-I (APA 1952) listed four categories of psychiatric disorder relating to personality: disturbances of pattern; disturbances of traits; disturbances of drive, control and relationships; and sociopathic disturbances. These forerunners of Personality Disorders were "used only when the patient did not fit comfortably in other categories" (Lenzenweger and Clarkin 1996). However, explicit diagnostic criteria did not appear until DSM-III in 1980.

It was also in DSM-III that Personality Disorders were first classified on a separate axis (Axis II) from other mental disorders (Axis I). Subsequent developments and debates involved the refining of the criteria for diagnosis.

For example, DSM-III used monothetic categories for diagnosis. These are set criteria that are necessary for diagnosis. Subsequent DSM systems have used polythetic categories where some of the criteria only are needed for diagnosis (eg: the presence of five from a list of seven to nine characteristics).

Currently ICD-10 (WHO 1992) and DSM-IV (APA 1994) are perceived as compatible, in the main, in their diagnostic criteria for Personality Disorders (table 1) [(2)].

DSM-IV divides the Personality Disorders into three common clusters (table 2).

The process of classification is never finished, and proposals for revisions are continually being discussed in committees preparing DSM-V for 2007. There is also ICD-11 due (Widiger 2001).

Livesley (2000) divides the history of Personality Disorders into three stages: pre-DSM-III; DSM-III phase; and post-DSM III era.

Livesley (2001) sees a variety of concepts of Personality Disorders that underlie current definitions. Personality Disorders as:

i) Extreme versions of mental disorders;
ii) A failure to develop aspects of the normal personality (ie: deficit);
iii) A particular type of personality structure;
iv) Abnormal personality compared to the majority.

The relationship between Personality Disorders and normal personality has focused on three key issues (Lenzenweger and Clarkin 1996):

ICD 10	DSM IV
Paranoid F60.0	Paranoid 301.0
Schizoid F60.1	Schizoid 301.20
Schizotypal* F21	Schizotypal 301.22
Dissocial F60.2	Antisocial 301.7
Emotionally unstable, borderline type F60.31	Borderline 301.83
Emotionally unstable, impulsive type	
Histrionic F60.4	Histrionic 301.50
	Narcissistic 301.81
Anxious F60.6	Avoidant 301.82
Dependent F60.7	Dependent 301.6
Anankastic F60.5	Obsessive-compulsive 301.4
Enduring personality change after catastrophic experience F07.0	
Enduring personality change after psychiatric illness	
Organic personality disorder**	Personality change due to general medical condition***
Other specific personality disorders and mixed and other personality disorders F60.9	Personality disorder not otherwise specified 301.9
	Passive-aggressive (negativistic)****
	Depressive****

* = included within section for schizophrenia, schizoptypal and delusional disorders.
** = included within section for organic mental disorders.
*** = included within section for mental disorders due to general medical condition not elsewhere classified.
**** = included within appendix as proposed criteria.

(After Widiger 2001)

Table 1 - Comparison of the categories of Personality Disorders in ICD 10 and DSM IV.

CLUSTER A	CLUSTER B	CLUSTER C
DISORDERS OF ODD OR ECCENTRIC BEHAVIOUR	DISORDERS OF DRAMATIC, EMOTIONAL OR ERRATIC BEHAVIOUR	DISORDER INVOLVING ANXIOUS OR FEARFUL BEHAVIOUR
Paranoid	Anti-Social	Avoidant
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Obsessive-Compulsive
	Narcissistic	

Table 2 - The three clusters of Personality Disorders in DSM-IV.

i) Are Personality Disorders extreme versions of normal personality traits on a continuum or separate categories?

ii) How to distinguish normal and abnormal personality traits, and the relationship between them?

iii) The underlying structure of personality and Personality Disorders (ie: the theoretical basis to personality).

DEPENDENT PERSONALITY DISORDER

Both ICD-10 and DSM-IV use the same term: Dependent Personality Disorder. It is placed in cluster C of the three clusters of Personality Disorders in DSM- IV.

HOW MANY SUFFERERS?

Establishing how many individuals suffer from a disorder is not easy, and often depends upon the method of study used. Table 4 summarises some of the main studies.

The mean rate of Dependent Personality Disorder is 2.2% (range 0-7.9) in non-clinical samples in studies between 1985-2003 (excluding Bornstein 1993). The figures vary for specialist samples (eg: inpatients in psychiatric hospitals) (table 3), and Flynn, Matthews and Hollins (2002) found a diagnosis rate of 28% among thirty-six individuals with mild or moderate learning disabilities in specialist challenging behaviour in-patient services.

In a sub-set of elderly patients with major depression, Abrams et al (1995 quoted in Clarkin and Abrams 1998) reported a 12% rate of Dependent Personality Disorder.

NUMBER OF STUDIES	TYPE OF SAMPLE (N)	RATE OF DEPENDENT PERSONALITY DISORDER (%)	RANGE
4	community (4150)	9	0-10
8	outpatients in psychiatric hospitals	4	2-47
6	inpatients at psychiatric hospitals	21	4-51

(DSM-III or DSM-IIIR used)

Table 3 - Summary of studies on rate of Dependent Personality Disorder between 1983-91 reported in Bornstein (1993).

The accuracy of figures from the different types of samples depends on a number of factors:

i) Accuracy of "community" samples depends upon the honesty of responses to questionnaires, or the accuracy of the measuring devices used;

STUDY	PREVALENCE PERSONALITY DISORDERS (%) Dependent	Any	CRITERIA	SAMPLE
Baron et al (1985)	0	/	DSM-III	374 USA random of non-ill relatives of patients with schizophrenia
Black et al (1993)	2.4	33.1	DSM-III	127 USA family members of volunteers to advertisements
Blanchard et al (1995)	2.2	/	DSM-IIIR	93 USA from adverts, or friends of motor vehicle accident survivors with PTSD
Bornstein (1993)	5.0	/	DSM-III/R	20 729 participants pooled data from 18 studies (see table 3)
Coid (2003)	1.0-1.7	4.4-13.0	DSM-IV	summary of 6 studies 1995-2001; community
Coryell & Zimmerman (1989)	0.5	14.6	DSM-III	185 USA first degree relatives of volunteers from advertisements
Drake & Vaillant (1985)	7.9	23.0	DSM-III	369 USA males in longitudinal study of juvenile delinquents began in 1940s (not sufferers)
Maier et al (1995)	1.6	9.4	DSM-IIIR	320 Germany first degree relatives of 109 community sample
Reich et al (1989)	5.1	11.1	DSM-III	235 USA responses to random questionnaire to 401 residents in mid-western university town
Samuels et al (2002) (3)	0.1/0.1	9.0/5.1	DSM-IV/ ICD-10	742 34-94 yrs random community sample in Baltimore between 1997-9

(Data from Coid 2003; Mattia and Zimmerman 2001; Samuels 2002)

Table 4 - Summary of main recent studies of the prevalence of Dependent Personality Disorder.

ii) Individuals with Dependent Personality Disorder may not seek treatment, and thus figures for "outpatients" samples could be underestimates. Individuals diagnosed with other disorders in

"outpatients" samples, and Dependent Personality Disorder symptoms missed. Thus underestimate.

iii) High rates in the "inpatients" samples may be due to "institutionalisation" which produces symptoms of dependency (Booth 1986). Thus overestimate possible.

GENDER DIFFERENCES AND DEPENDENT PERSONALITY DISORDER

The studies in table 5 show significant gender differences in the rate of Dependent Personality Disorder. Bornstein (1993) reported a prevalence rate of 11% for women and 8% for men.

STUDY	SAMPLE	RATE OF DEPENDENT PERSONALITY DISORDER (%)		
		FEMALE	MALE	OVERALL
Alnaes & Torgerson (1988)	298 outpatients	48	46	47
Hayward & King (1990)	45 community	0	0	0
Jackson et al (1991)	112 inpatients	25	11	17
Kass et al (1983)	2192 community	11	5	8
	531 outpatients	9	4	7
Reich (1987)	170 outpatients	27	16	24
Stangler & Printz (1980)	500 outpatients	4	4	4
Zimmerman & Coryell (1989)	797 community	3	0	2
TOTAL		11*	8**	

* X2 = 0.0005
** Male total calculation includes two other studies which did not give female breakdown: Drake et al (1988) 396 community sample and 10% rate; Poldrugo & Forti (1988) 404 outpatients and 4% rate of Dependent Personality Disorder

(DSM-III and DSM-IIIR used)

Table 5 - Summary of studies showing gender differences in the rate of Dependent Personality Disorder 1983-91 reported in Bornstein (1993).

Do the gender differences in the prevalence of Dependent Personality Disorder imply "something inherent about females, something about the way women are socialised in our society, and/or something about the biases that diagnosticians bring to this personality

disorder" (Peterson 1996 p399)?

Pilgrim and Rogers (1993) offer three possible explanations for the differences in rates of mental illness between men and women:

i) Society causes female mental illness through, for example, sex role expectations;

ii) Methodological weaknesses in the collection of the data. This is discussed below in relation to Dependent Personality Disorder;

iii) The labelling of traditional female behaviour as mental illness. This is explored later in the "Problems with Personality Disorders" section.

Methodological Weaknesses

a) Observer bias.

Where gender differences are measured by questionnaires rather than diagnostic interviews or observer ratings, the size of the difference is reduced. This would suggest observer bias in the diagnostic interview or observer rating (Yeger and Miezitis 1985).

> In other words, in the minds of clinicians and clinical researchers, femininity may be so strongly associated with dependency that when a person appears feminine, dependency is "automatically" (ie: unconsciously and reflexively) attributed to that individual (Bornstein 1993 p131).

Widiger and Spitzer (1991) call this process "diagnostic sex bias".

ii) The setting of the data collection.

Widiger and Spitzer (1991) noted that the characteristics of the setting can influence the findings; eg: Veterans Administration (VA) hospital compared to State psychiatric hospital or private facility.

iii) Gender bias in the diagnostic criteria.

A "criterion sex bias" (Widiger and Spitzer 1991). The concern that "some Axis II diagnoses reflect normal

sex-role related behaviours that have been inappropriately labelled as pathological" (Bornstein 1993 p131).

WHAT IS DEPENDENT PERSONALITY DISORDER?

Pre-DSM-III

The concept of dependency as a problem has existed throughout the twentieth century, but it was not formalised until DSM-III (1980).

Fromm (1947) had pointed out that sufferers "feel lost when alone because they feel that they cannot do anything without help" (p62), and Millon (1981) noted that the dependent persons' "centres of gravity" lies in others:

> To protect themselves, dependents quickly submit and comply with what others wish, or make themselves so pleasing that no one could possibly want to abandon them (p107).

Bornstein (1993) offers a "working definition" of the dependent personality type based on four components:

i) Motivational - the need for guidance, support, and approval of others;

ii) Cognitive - the perception of the self as powerless and others as powerful;

iii) Affective - anxiety about being independent, or being evaluated;

iv) Behavioural - seeking help and approval from others, and thus yielding to them to maintain it.

In DSM-I (APA 1952), "dependent personality disorder" was included as a subtype of the "passive-aggressive personality", "passive-dependent type". This was characterised by "helplessness, indecisiveness, and a tendency to cling to others as a dependent child to a supporting parent" (p37). In DSM-II (APA 1968), it was included in "other personality disorders of specified types", but there was no description of the symptoms of "passive-dependent personality disorder".

DSM-III and After

DSM-III (APA 1980) defined Dependent Personality Disorder based on three broad symptoms: (i) passivity in relationships, and an inability to function independently; (ii) the subordination of own needs to others; and (iii) a lack of self-confidence.

Really it was not until DSM-IIIR (APA 1987) that clear symptoms of "a pervasive pattern of dependent and submissive behaviour, beginning in early adulthood and present in a variety of contexts" (p354) were described. Five or more of nine symptoms were required for diagnosis:

1. Unable to make independent decisions
2. Lets others make important decisions
3. Excessive fear of rejection
4. Difficulty in initiating events and activities
5. Volunteers to perform unpleasant tasks in order to please others
6. Feels helpless when alone
7. Devastated when important relationships end
8. Preoccupied with fears of abandonment
9. Easily hurt by criticism or disapproval

Symptoms 1, 2, 4 and 5 are behavioural, and the others are affective. Application 1 shows an example of the use of the diagnostic criteria.

APPLICATION 1

"CASE 1" (Benjamin 1996): Married woman with child.

Application of DSM-IIIR criteria in diagnosis:

1. Unable to make everyday decisions without help of mother, who lives nearby, and husband.

2. Also for important decisions.

3. Agreed with others when thought wrong - eg: agreeing with mother to keep happy, or telling cousin's story of child sexual abuse when group therapist wanted more details.

6. Upset when alone - eg: found sobbing by husband late at night: "I want my mommy".

8. Could not imagine surviving without mother or husband.

9. Can't handle criticism - eg: upset when mother criticised her for always asking for help.

Bornstein (1993) noted a problem with the DSM-IIIR criteria, and it is also relevant to DSM-IV. The criteria are not completely independent. For example, symptoms 1 and 2 are clearly related, and it is difficult to show one without the other, as are symptoms 7 and 8.

DSM-IV removed symptom 3 from above, and defined Dependent Personality Disorder as:

> A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning in early adulthood and present in a variety of contexts..
> (DSM-IV-TR APA 2000).

For diagnosis of Dependent Personality Disorder, DSM-IV requires the presence of at least five of the eight symptoms (applications 2,3 and 4):

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.

2. Needs others to assume responsibility for most major areas of life.

3. Has difficulty expressing disagreement with others because of fear of loss of support or approval.

4. Has difficulty initiating projects or doing things on own (because of lack of self-confidence than motivation or energy).

5. Goes to excessive lengths to gain nurturance and support from others, to point of volunteering to do things that are unpleasant.

6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for self.

7. Urgently seeks another relationships as a source of care and support when a close relationship ends.

8. Unrealistic preoccupation with fears of being left to take care of self (DSM-IV APA 1994 pp668-669).

APPLICATION 2

"Matthew" (Spitzer et al 1994) 34-year-old single man living with mother.

Application of DSM-IV criteria in diagnosis:

3. Unhappy and angry with self because mother had told him not to marry girlfriend, and he had obeyed.

5. Turned down promotion to remain near to two very close friends.

6. Has lunch with two friends every workday and feels lost if friends miss day.

7. Wants to find new girlfriend as soon as last relationship ended.

8. Has not left mother's home except for one year at college, but returned because of homesickness; also separation anxiety as a child.

APPLICATION 3

"Mr.G" (Millon 1969).

Application of DSM-IV criteria in diagnosis:

1. Worked in father's tailoring shop, but mother made sure he did no "hard or dirty work"; only son of six children, mother kept watch and limited his responsibilities as child; also 19-year-old son of first marriage guided his father's affairs.

2. First marriage arranged by parents to "sturdy woman".

4. Lost job when factory closed, and then stayed at home waiting for something to happen.

5. Teased at work, but willing to run errands and buy cigarettes for work-mates.

7. Married second time to "motherly type".

APPLICATION 4

"Sarah D" (Carson et al 1998) Married mother of two children.

Application of DSM-IV criteria in diagnosis:

1/2. Reported to "crisis centre" after physical abuse by husband needing to know what to do.

3. Not critical of husband's regular abuse.

4. Attempts to leave husband in past failed because of fear of "not being with M".

5. Physical abuse by husband with addiction problem, who then left. Her main concern about return of husband, and played down abuse.

6. Great concern about surviving on her own, though in well-paid job.

7. Similar relationships with first husband.

Non-clinical definitions

Gelder et al (1996), in their textbook of psychiatry, include two paragraphs about Dependent Personality Disorder. These are the main points they made:

i) Weak-willed and "unduly compliant with wishes of others";

ii) Lack vigour and "little capacity for enjoyment";

iii) Avoid responsibility and lack self-reliance;

iv) Can achieve their aims by persuading others to help them while protesting their helplessness;

v) If married, a "determined spouse" can make decisions etc;

vi) "..left to themselves, some drift down the social scale and others are found among the long-term unemployed and the homeless" (p117).

While Alloy et al (1993) emphasised the dependence on others, and the handing over of decisions to others. They see these symptoms as manifestations of the fear of abandonment, which can lead to mistreatment by those in control. The authors tend to see the sufferers as female.

Brown (1992) would rather see the cause in society than in the individual. Ussher (2000) summarises the feminist critique of mental illness among women:

> Within a heterosexual matrix, the traditional script of femininity tells us that women live their lives through men. To have a man, and keep him, is the goal of every girl's life.. The "good girl" is inevitably self-sacrificing, but she always gets her man.. the sexual woman is always deemed to deserve all the condemnation she gets.. Women are taught to gain happiness through relationships, invariably with men. They are also taught that it is their fault if these fail (p220).

Sadock and Sadock (2003) note the characteristics of pessimism, self-doubt, passivity, and fears of expressing sexual and aggressive feelings: "An abusive, unfaithful, or alcoholic spouse may be tolerated for long periods to avoid disturbing the sense of attachment" (p814).

Comer's (2002) emphasis is upon the pattern of clinging, obedience, fear of separation, and the need to be taken care of. Overholser (1996) noted the dependency on a parent or spouse for where to live, what job to do, and which neighbours to like. Sufferers are sad, lonely, and dislike themselves.

Recently, an internet-related version of Dependent Personality Disorder has been noted, characterised by "excessively depending on a cyber-being and on numerous fellow users, ever seeking their company, guidance, and reassurance, and fearing separation (Comer 2002 p433). Such individuals can spend up to sixty hours per week in chat groups. However, this behaviour has also been linked to "substance-related disorder" or "impulse-control disorder" patterns by other researchers.

There is also the situation of a shared psychotic disorder ("folie a deux") where the submissive member of the pair (with Dependent Personality Disorder) takes on the delusional system of the more assertive other (Sadock and Sadock 2003).

OVERLAPS IN SYMPTOMS

Comer (2002) notes a number of prominent and central features of Dependent Personality Disorder which it has in common with other Personality Disorders, "leading to frequent misdiagnoses or to multiple diagnoses for a given client" (p409) (table 6).

The symptoms of Dependent Personality Disorder do overlap with other Personality Disorders and mental disorders, like all categories of mental illness. The key is to differentiate in diagnosis.

PROMINENT FEATURES DEPENDENT PERSONALITY DISORDER	NUMBER OF PERSONALITY DISORDERS WITH SAME FEATURE (out of 9)
suspicious/distrust	6
controlling/ manipulative	4
sensitive	5
depressed/helpless	8

PERSONALITY DISORDERS WITH 4 PROMINENT FEATURES IN COMMON WITH DEPENDENT PERSONALITY DISORDER
Borderline; Histrionic; Narcissistic

PERSONALITY DISORDERS WITH 3 PROMINENT FEATURES IN COMMON WITH DEPENDENT PERSONALITY DISORDER
Paranoid; Schizotypal

PERSONALITY DISORDERS WITH 2 PROMINENT FEATURES IN COMMON WITH DEPENDENT PERSONALITY DISORDER
Anti-Social; Avoidant; Obsessive-Compulsive

PERSONALITY DISORDERS WITH 0 PROMINENT FEATURES IN COMMON WITH DEPENDENT PERSONALITY DISORDER
Schizoid

CENTRAL FEATURES OF DEPENDENT PERSONALITY DISORDER
relationship problems - feature in all other Personality Disorders
self-critical - feature in 4 other Personality Disorders
anxious/tense - feature in 6 other Personality Disorders

WHERE DEPENDENT PERSONALITY DISORDER DISTINCT
self-absorbed: Dependent Personality Disorder only one not having this feature
aloof/isolated: one of 4 Personality Disorders not having this feature
hostile: one of 4 Personality Disorders not having this feature

(Data from Comer 2002)

Table 6 - Comparison of prominent and central features between Dependent Personality Disorder and other Personality Disorders.

> Many individuals display dependent personality traits. Only when these traits are inflexible, maladapted, and persisting and cause significant functional impairment or subjective distress do they constitute dependent personality disorder (DSM-IV APA 1994 p668).

The characteristic of dependency can also be found in mood disorder, panic disorder and agoraphobia, or mental disorder caused by general medical condition, according to DSM-IV. But for Dependent Personality

Disorder, the dependency has an early onset, and is stable over time. Table 7 gives examples of overlapping symptoms among Dependent Personality Disorder and three other Personality Disorders.

SYMPTOM	DEPENDENT PERSONALITY DISORDER	OTHER PERSONALITY DISORDERS
fear of abandonment	respond with submissiveness	Borderline - respond with emptiness/rage
need for approval	leads to docile behaviour	Histrionic - produces flamboyant active demands for attention
hypersensitive to criticism	maintain relationships	Avoidant - leads to withdraw from relationships

Table 7 - Comparison of overlapping symptoms between Dependent Personality Disorder and three other Personality Disorders.

Comer (2002) notes similar symptoms of Dependent Personality Disorder with Separation Anxiety Disorder, and Dysthymic Disorder (table 8).

	SEPARATION ANXIETY DISORDER	DYSTHYMIC DISORDER
1. Common features with Dependent Personality Disorder		
	- "persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings" (DSM-IV APA 1994 p113)	- low self-esteem - feelings of hopelessness - difficulty making decisions
	- emphasis on separation fears	
2. Differences to Dependent Personality Disorder		
	- physical symptoms related to separation in Separation Anxiety Disorder	- motivation of above due to depression in Dysthymic Disorder
	- Separation Anxiety Disorder usually associated with children	- other depressive symptoms (eg: eating and sleeping problems) in Dysthymic Disorder

Table 8 - Similarities and differences between Dependent Personality Disorder and Separation Anxiety Disorder and Dysthymic Disorder.

PROBLEMS WITH PERSONALITY DISORDERS

Livesley (2001) admitted that a "consensus seems to be emerging among clinicians and researchers that there are fundamental problems with the DSM classification of personality disorders" (p16).

Parker (1998) noted that: "The DSM three-cluster argot of 'eccentric', 'dramatic', and 'anxious and fearful' types has been widely accepted, despite the lack of empirical support.."(p125).

The problems with Personality Disorders can be explored through five areas.

1. Personality Categories or Dimensions

DSM-IV sets out criteria for the diagnosis of each Personality Disorder. But each description is "an idealised typical case" which is not found in real life (Farmer et al 2002). These are based on the idea of types or traits (4), which goes against the current view on measuring personality as dimensions (eg: Costa and McCrae 1992; Five-Factor Model; FFM) (5).

But the use of dimensions would assume that the characteristics are present in all individuals, but exaggerated in those with Personality Disorders (Marlowe 1996).

The use of types or prototypes means that there has to be a cut-off point. Who decides the cut-off point for inclusion or exclusion within the category? Often a panel of experts (Widiger 1993).

If the cut-off point is the presence of five characteristics from a list, how to view the individual with four of those characteristics, and how do they compare to an individual with one (Widiger and Corbitt 1994)?

The alternative approach would be to link Personality Disorders to the theories of personality dimensions. Trull (2000) sees the idea of "dimensional" models of personality and Personality Disorders covering a number of approaches:

i) Quantify each symptom to show the degree of presence (eg: Widiger 1993);

ii) Identify traits that underlie Personality Disorders. For example, factor analysis of the Personality Disorder criteria to reveal the dimensions underlying them (eg: Livesley and Jackson 1986; found 18 trait dimensions);

iii) The use of personality traits as the basis of Personality Disorders independent of the DSM-IV criteria.

Cloninger et al (1993) suggest that Personality Disorders may be extremes of specific dimensions of personality rather than all dimensions. They divide personality traits into "temperament traits" (eg: novelty-seeking) and "character traits" (eg: co-operativeness). It is the extreme version of the latter that would define Personality Disorders.

Cloninger (2000) refined this idea to argue that Personality Disorders could be defined by two of the following four "character traits": low scores on self-directiveness, co-operativeness, affective stability, and self-transcendence.

While a cluster C Personality Disorder would link to the FFM as high scores on Neuroticism, Agreeableness and Conscientiousness, and low scores on Extraversion and Openness (relationship unclear) (Farmer et al 2002).

Recent research has concentrated on the link between personality trait models and Personality Disorders, particularly the idea of a continuum between normality and abnormality on specific traits.

Mulder and Joyce's (1997) factor analysis of the Personality Disorder symptoms of 148 patients produced a four factor model: "anti-social", "asocial", "asthenic", and "anankastic". This last factor was separately loaded by Obsessive-Compulsive Personality Disorder, and challenges the cluster C home for this disorder in DSM-IV (Parker 1998).

After the factor analysis, scores on the Structured Clinical Interview for DSM-III (SCID) (6) were correlated with "normal" personality questionnaires - Eysenck Personality Questionnaire (EPQ) (Eysenck and Eysenck 1975) (7) and Tridimensional Personality Questionnaire (TPQ) (Cloninger et al 1991) (8) (table 9). Parker (1998) feels that Personality Disorders are the "extremes of normally distributed human temperament measures".

FACTOR MODEL	EPQ	TPQ
anti-social	psychoticism (P)	novelty-seeking
asocial	psychoticism (P)	reward dependence
asthenic	neuroticism (N)	harm avoidance

Table 9 - Correlations between personality factors and two personality questionnaires found by Mulder and Joyce (1997).

Blais (1997) looked at 100 patients with Personality Disorders and the FFM. The Personality Disorders linked best to the three dimensions of Neuroticism (N), Extaversion (E), and Agreeableness (A).

Developing from this, Saulsman and Page (2003) note that the FFM reveals:

> the general personality traits underlying personality disorders, but (as) it does not account for all variance in personality disorders and appears to have difficulty differentiating specific personality disorders..(p85)

Common to all Personality Disorders, except Dependent Personality Disorder, with the FFM are high N (Neuroticism) and low A (Agreeableness). Extraversion (E) and Conscientiousness (C) are linked to Personality Disorders but as associated variables, and Openness (O) has no association with any Personality Disorder. There are patterns for some specific Personality Disorders (table 10).

PERSONALITY DISORDER	FFM DIMENSIONS
Paranoid	high N; low A
Anti-Social	low A; low C
Avoidant	high N; low E

(After Saulsman and Page 2003)

Table 10 - Examples of relationships between specific Personality Disorders and FFM dimensions.

Duggan et al (2003), used for their study, 34 men with an offending history and a Personality Disorder in UK regional secure units. The researchers correlated the scores on the NEO-FFI (Neuroticism, Extraversion, Openness - Five Factor Inventory) (Costa and McCrae 1990) with the International Personality Disorder Examination (IPDE) (Loranger et al 1994). Table 11 shows the significant correlations found. The sample used in this study was small and biased (ie: offenders).

In other words, it is possible to distinguish normal from disordered personality as deviation from the norm, extreme elevation, inflexibility, distress, and impairment in functioning (Saulsman and Page 2003).

But such an idea "seems to embrace an ideal concept of normality" which would blur the distinction between

normality and clinically significant impairment even more, and "trivialising the disorder by creating a conception that would apply to a sizeable proportion of the population" (Liveley 2001 p25).

PERSONALITY DISORDER (No of sample)	N	E	O	A	C
Paranoid (9)*	(high)	(low)	(low)	(low)	low
Schizoid (4)		low			
Schizotypal (5)		low			
Anti-Social (26)					low
Borderline (21)	(high)		low		low
Histrionic (6)			low		
Narcissistic (3)					
Avoidant (11)		low			
Dependent (4)	high		(low)		
Obsessive-Compulsive (3)		low			
Passive-aggressive (15)	high		low		
Sadistic (7)				(low)	
Self-defeating (3)	(high)				

* = dual diagnosis means totals greater than 34; significance = 0.05 or (0.01)

(After Duggan et al 2003)

Table 11 - Summary of significant correlations between Personality Disorders and FFM found by Duggan et al (2003).

2. Measurement of Personality Disorders

Whether the questionnaire is self-reported (eg: Personality Assessment Inventory; PAI; Morey 1991) (9) or part of a diagnostic interview (eg: Personality Disorder Interview; PDI-IV; Widiger et al 1995) (10), the assumption is that personality types will show a pattern of responses to a series of choices.

The scores will be compared to established norms. Well known general personality tests, like the Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway and MacKinley 1967) are well researched, and have established

validity and reliability scores (11). But, in practice, this focus on reliability, validity and norms has ignored the fact that the underlying assumptions for their design have problems.

i) The assumption that personality is stable.

Tickle et al (2001) admit that:

> Fluctuation in the expression of traits is expected: personality traits seem to be stable over time, but they do undergo slight state fluctuations in the short term. In other words, traits provide a basic personality framework which remains stable in the long term and allows patterns of responses to be established. There exists, however, a range of behaviours and other trait expressions that occur within this framework of stability (p246).

Wetherell and Maybin (1996), taking a social constructionist position, argue that the personality is the product of social situations. It is "the sum and swarm of participation in social life" (Bruner 1990), and thus tends to change based on the situation.

The personality (or self, as preferred by social constructionists) is "always located in the situation in which the individual is existing. Identity is multi-faceted, but based on key relational settings" (Brewer 2001a p33). The concept of a stable personality is completely challenged, and so is the idea of a stable Personality Disorder.

The method of assessing personality will also influence the findings of stability or not of the personality (Heatherton and Nichols 1994). For example, self reporting scales of 1-5 tend to find stability because individuals who choose one extreme are unlikely to choose the other extreme next time. Maybe a change from 4 or 5 to 3. Or individuals may select the middle position each time.

ii) The assumption that certain patterns of responses show certain personality types.

It assumed that the views expressed are fixed attitudes which are linked to underlying personality traits. Billig (1991) challenges this idea: for him, attitudes are not "individual evaluative responses towards a given stimulus object. Instead, attitudes are stances taken in a matter of controversy: they are positions in arguments" (quoted in Potter 1996 pp160-

161).

The upshot is that individuals express different views depending on the situation, and what action it is the want to achieve with that attitude (Potter 1996). Thus different responses will be given to personality questionnaires depending on the situation, who is administering the questionnaire and so forth.

iii) Often the psychometric questionnaires are based upon the assumption of a normal distribution of answers.

iv) These questionnaires are able to detect patterns of symptoms, but are these patterns really a Personality Disorder?

The official answer is yes, because that Personality Disorder is shown by those symptoms. And so the argument goes round.

Specifically, Bornstein (1993) admits that the internal validity of the Dependent Personality Disorder symptoms is "reasonably strong", but not the external validity. Internal validity relates to clusters of symptoms together as predicted by the classification system. While external validity is the relationship between Dependent Personality Disorders symptoms and specific independent behaviours. Bornstein (1993) is particularly concerned about symptom 4 in DSM-III: difficulty in initiating events or activities.

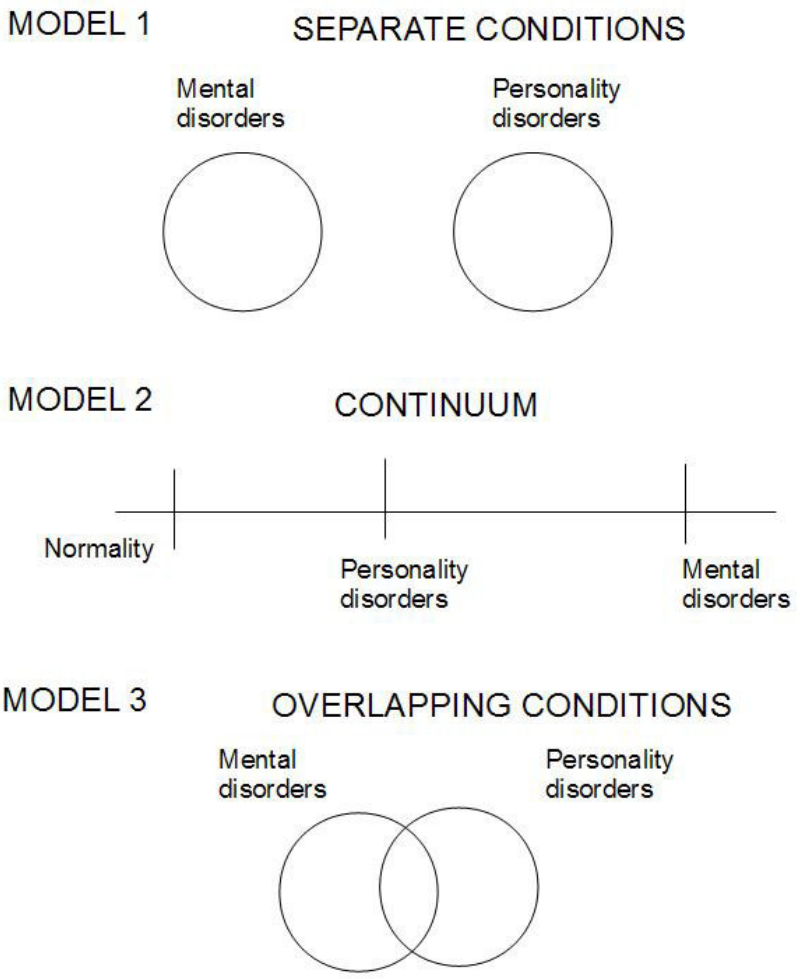
Usually this situation can be resolved by establishing the validity of the criteria by correlation with expected independent behaviours. For example, a high score on an IQ test should positively correlate with intelligent behaviour in everyday life (eg: doing crosswords, answering quiz questions). There are no clear independent behaviours for Personality Disorders - no "gold standard" (Lenzenweger and Clarkin 1996).

This is important to note because the reliability of measurement methods for Personality Disorders can and have been established. Reliability and validity are two different concepts, and gaining one does not automatically mean the other is achieved as well (Coolican 1990) (12).

3. The distinction between Personality Disorders and mental disorders

Foulds (1976) attempted to establish possible models for the relationship between Personality Disorders and mental disorders. Three of the models are important to

mention here (figure 1).



(After Freeman 1993)

Figure 1 - Three possible relationships between mental disorders and Personality Disorders.

DSM-III was first to make the distinction between Axis-II (trait-related) problems of Personality Disorders and learning disabilities, and Axis-I (state-related) mental disorders. This would suggest model 1 in figure 1, or is it model 3?

"Psychiatrists, and perhaps British psychiatrists more than most, are ambivalent about whether to regard personality disorders as mental illness" (Kendell 2002 p110). Mental illness, or more specifically mental disorder, is not an exact term, in the sense of allowing it to be used as for deciding what is and is not a mental

disorder (Kendell 2002).

In fact, DSM-IV has a 146-word definition of mental disorder, which sets up the existence of a "clinically recognisable set of symptoms" (Kendell 2002). But thus can be typical of psychology (and psychiatry), it is easier to spot a behaviour than to define it.

Kendell (2002) argues that the problem with establishing the relationship between Personality Disorders and mental disorders relates to the different concepts of "disorder" generally used in medicine and psychiatry. There are four main concepts:

a) Socio-political - a disorder is a condition that is accepted as undesirable;

b) Biomedical - an abnormal phenomena that places the species at a "biological disadvantage";

c) Biomedical and socio-political - a disorder is a biological dysfunction (ie: the failure to perform a natural function), and thus accepted as undesirable;

d) Ostensive - disorder as a prototype category.

> It seems clear.. that it impossible.. to decide whether personality disorders are mental disorders or not, and that this will remain so until there is an agreed definition of mental disorder (Kendell 2002 p113).

Gelder et al (1996) emphasised the role of unusual behaviour in making this "not always easy to make" distinction between Personality Disorders and mental disorders.

> If the personal has previously behaved normally and then begins to behave abnormally, he is said to have a mental disorder. If the person has always behaved abnormally, he is said to have a personality disorder (p105).

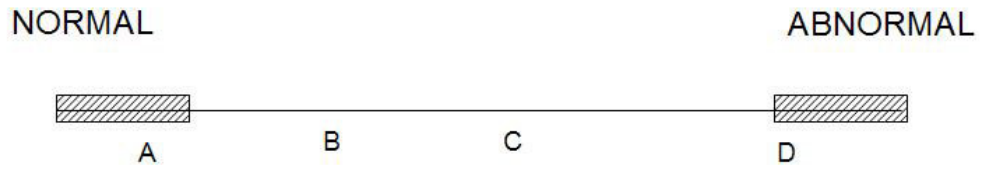
Siever and Davis (1991) suggest that there is a continuum between Personality Disorders and mental disorders based on four behavioural processes: cognitive/perceptual; impulsivity/aggression; affective instability; and anxiety/inhibition.

As to whether Personality Disorders and mental disorders are on a continuum or are distinctly different has always remained a question throughout the classification of mental illness.

There are difficulties with Gelder et al's distinction:

i) Problems of defining "normality".

Brewer (2001b) noted the problems with establishing what is normal or abnormal using a continuum (figure 2).



(After Brewer 2001b)

Figure 2 - Normal-abnormal continuum.

Some abnormalities are slight (area A in figure 2) and fall within the range of normal variation, while area D is clearly abnormal. The problem relates to points B and C, and which is normal or abnormal. This may vary depending on circumstances, culture, or the individual involved. In other words, the division between normal and abnormal is not fixed.

Table 12 gives examples of these problems for Dependent Personality Disorder.

POINT ON FIGURE 2	APPLICATION TO DEPENDENT PERSONALITY DISORDER
A	need advice from others before major career change (normal)
B/C	need help to decide which university to attend. Whether this is a problem depends on the individual being a teenager or middle aged, for example
D	cannot make ordinary decisions, like getting dressed without help of others on what to wear

Table 12 - Dependent Personality Disorder and examples of positions on the continuum of normality and abnormality.

ii) Unusual behaviour not spotted before.

iii) How to assess if unusual behaviour is permanent or temporary?

iv) Some behaviour changes are slow (eg: onset of some forms of schizophrenia).

v) Dependent Personality Disorder is sometimes classed as an "immature" Personality Disorder, which means that it improves over time (Tyrer et al 1993). This challenges the idea of a stable and enduring pattern as distinct from mental disorders.

4. Gender and Personality Disorders

There is concern that the diagnostic criteria for Personality Disorders are biased towards a particular gender. Frances et al (1995) argued that the inclusion of stereotypically feminine characteristics in the diagnostic criteria will lead to a bias towards the overdiagnosis of women. Dependent Personality Disorder is one such disorder.

Kaplan (1983) argued that the DSM-III criteria for Dependent Personality Disorder are quite similar to the traditional female sex-role, and "singles out for scrutiny and therefore diagnosis the ways in which women express dependency but not the ways in which men express dependency" (p789).

For example, the financial dependence of the non-working wife on the working husband is symptomatic of Dependent Personality Disorder, but not the dependency of that husband on the wife to maintain the household and perform the child-rearing tasks (Bornstein 1993).

Studies with college students have found that the DSM-III and DSM-IIIR criteria of Dependent Personality Disorder are viewed as traditional feminine behaviour more often than traditional masculine behaviour (eg: Landrine 1989).

But in studies with psychiatrists and fictitious case histories, females were not more likely to be diagnosed with Dependent Personality Disorder than men (eg: Adler et al 1990).

On the other hand, Corbitt and Widiger (1995) argue that the differences in diagnosis rates of Personality Disorders may just be the gender differences in certain personality traits. Using the overdiagnosis of women with Histrionic Personality Disorder as an example, Widiger (2001) points out that the solution is not to make the criteria more masculine, but to increase the "behavioural specificity of the diagnostic criteria" (p76).

In other words, there is nothing intrinsically wrong with the Personality Disorder categories, it is just a

question of tinkering with the diagnostic criteria.

Throughout the history of DSM, there have been criticises about the gender bias of disorders. For example, Masochistic Personality Disorder in DSM III was changed to Self-Defeating Personality Disorder in DSM IIIR, and placed in the appendices. It was then removed from DSM IV because of pressure from feminist groups (Kirk and Kutchins 1992).

To counter the inherent gender bias towards greater female diagnosis, Caplan (1991) "invented" Delusional Dominating Personality Disorder (DDPD), which was rejected by the APA DSM committee.

There would be fourteen symptoms of this disorder, including "A tendency to feel inordinately threatened by women who fail to disguise their intelligence" or "a pathological need for flattery about one's sexual performance and/or the size of one's genitalia". To some degree, DDPD was a spoof, but there was a serious point about DSM and the pathology of women (Griffin 1997).

5. "Post-modern self" and Personality Disorders

"Post-modern" is a commonly used term today, but it is an "amorphous thing": "The term itself hovers uncertainly in most current writings between - on the one hand - extremely complex and difficult philosophical senses, and - on the other - an extremely simplistic mediation as a nihilistic, cynical tendency in contemporary culture" (Docherty 1993 p1).

Polkinghorne (1992) lists the themes of "post-modern thought" as:

i) Foundationlessness - there are no universals; "no sure epistemological foundation upon which knowledge can be built".

ii) Fragmentariness - reality is "a disunited, fragmented accumulation of disparate elements and events.

iii) Constructivism - there is no world "out there" to discover, all knowledge is constructed; "human experience consists of meaningful interpretations of the real".

iv) Neopragmatism - the criteria for understanding are not whether knowledge corresponds to reality, because this cannot be known in the "post-modern" world. Rather it is whether knowledge "functions successfully in guiding human action to fulfil intended purposes".

From a social constructionist point of view, the self is a product of culture and society. Thus the type of society will influence (even determine) the self.

> As people live their lives they are continually making themselves as characters or personalities through the ways in which they reconcile and work with the raw materials of their social situation (Wetherell 1996 p305).

Gergen (1991) sees the condition of "multiphrenia" being at the heart of the "post-modern self". This is a "new constellation of feelings and sensibilities, a new pattern of self-consciousness involving the splitting of the individual into a multiplicity of self-investments" (pp73-4).

What happens in practice is that the self becomes "an open slate... on which persons may inscribe, erase, and rewrite their identities as the ever-shifting, ever-expanding, and incoherent networks of relationships invites or permits" (p228).

Gergen (2000) expands on this aspect of the "post-modern self". Individuals are "fractionated beings" because of:

a) "Polyvocality" - "the plethora of conflicting information and opinion".

b) Plasticity - rapid change and throwaway relationships, which leave the inner life as a luxury.

c) Repetition - individuals echo the media; eg: saying "I love you" to someone comes from romantic novels.

d) Transcience - many and varied roles.

The key notions, then, are uncertainty and change (Stevens and Wetherall 1996).

For some writers, this experience is negative or even pathological: today's self is "a mixture of disillusionment, boredom, confusion and celebration" (Thomas 1996). Frosh (1991) sees "narcissistic personality disorders" as a direct result of "post-modern society". These are a product of ego defence mechanisms that overevaluate a self that is threatened by the insecurity of the "post-modern".

Gottschalk (2000) takes the idea of the "post-modern self" being one of pathology further:

> post-modern selfhood proceeds across a landscape constantly radiating with 'low-level fear' and saturated by compelling media voices which obsessively recite stories of permanent catastrophe, random brutality, and constant dissatisfaction (p37).

Thus "insanity" can be seen as a normal response to "post-modern society". Gottschalk lists the characteristics of "post-modern society", along with "low-level fear", that "normalise, celebrate, and make acceptable psychosocial dispositions that... are fundamentally unhealthy" (p38):

a) "Telephrenic maps" - the intrusion of the media into the self, and the construction of reality through the camera.

b) "Tense ambivalence" - for example, borderline dispositions, which "oscillate between complete indifference and passionate involvement" (pp28-9). DSM-IV provides the label for such behaviour as "borderline personality disorder".

> Borderline patients often struggle to maintain coherence in their selves against forces of excessive splitting of aspects of reality. It may be that their selves have already begun to collapse (Thomas 1996 p328).

c) "Reasonable suspicion" (or even paranoia in some cases).

d) "So fast so numb" - gratuitous images of death and dying. Writers have called this "necrophilic television" (Robbins 1994: "the catastrophic and the banal are rendered homogeneous and consumed with equal commitment") or the "pornography of dying" (Burgin 1990).

e) "Sociopathic" characteristics including caring for the self only.

FOOTNOTES

1. Personality Disorder is written with capitals to refer to specific categories used by psychiatrists. When written in small letters, it refers to the concept of personality problems or disorders.

2. The categories of Personality Disorders in ICD-10 and DSM-IV are developments from earlier categories in ICD-9 and DSM-IIIR, for example (table 13).

ICD-9	DSM-IIIR
	Paranoid
Affective	
Schizoid	Schizoid
	Schizotypal
Explosive	
Anankastic	Obsessive-Compulsive
Hysterical	Histrionic
Asthenic	Dependent
Personality disorder with predominantly sociopathic or asocial manifestation	Anti-social
Other personality disorder	Narcissistic
	Avoidant
	Borderline
	Passive regressive
Unspecified	Personality disorder not otherwise specified

Table 13 - A comparison of the categories of Personality Disorder in ICD-9 and DSM-IIIR.

3. Samuels et al (2002) found cluster C Personality Disorders were greater in non-married individuals (6.6 adjusted odds ratio), and in those with high school education only (5.0 odds).

4. The trait and type theories of personality assume a hierarchical structure for personality based on levels of traits (eg: surface or higher order) (figure 3) (Thomas 2002).

5. The Five-Factor Model (FFM) sees personality as based on the interaction of the positioning of the individual on five trait dimensions, Each one is subdivided into six facet traits (Livesley 2001) (table 14).

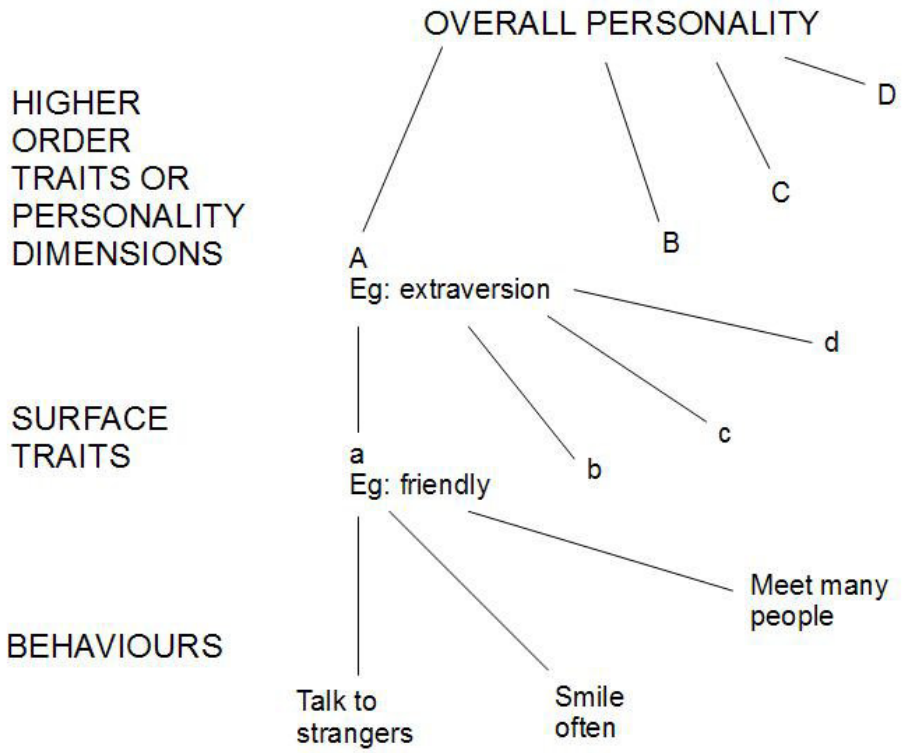


Figure 3 - Example of hierarchical structure of personality.

Neuroticism	anxiety, hostility, depression, self-consciousness, impulsivity, vulnerability.
Extraversion	warmth, gregariousness, assertiveness, activity, excitement seeking, positive emotions.
Openness to experience	fantasy, aesthetics, feelings, actions, ideas, values.
Agreeableness	trust, straightforwardness, altruism, compliance, modesty, tendermindedness.
Conscientiousness	competence, order, dutifulness, achievement striving, self-discipline, deliberation.

Table 14 - Facet traits of FFM.

6. The latest version is Structured Clinical Interview for DSM-IV Axis-II Personality Disorders (SCID-II) (First et al 1997).

7. EPQ measures three dimensions of personality:

introvert-extravert (E); neurotic (or emotional)-stable (N); and psychoticism (P).

8. TPQ measures "temperment traits" of novelty-seeking (eg: "seeks thrilling adventure"; "spends on impulse"); reward dependence; and harm avoidance (fear) (Depue and Lenzenweger 2001).

9. Personality Assessment Inventory contains 344 items with a 4 point scale that takes 50 minutes to complete (Clark and Harrison 2001).

10. Personality Disorder Interview is based on 93 items scored by the interviewer as 0 (absence), 1 ("at-or-above threshold level of criteria"), or 2 (prominent characteristic) during a 90 minute interview (Clark and Harrison 2001).

11. "Good" psychometric tests will have established reliability and validity

Reliability - consistency of the test.

i) Test-retest: consistency over time by correlating the score on the same test by the same individual at two points in time.

ii) Parallel forms: correlation between two versions of the same test.

iii) Internal: consistency of the test (eg: split-halves correlation of odd number and even number question scores).

Validity - degree to which the test measures what it claims to measure.

i) Face/content: questions appear to measure what they claim to measure.

ii) Construct: relationship between a theoretical construct and the test.

iii) Convergent/concurrent: correlation between scores on two independent tests of the same construct.

iv) Criterion: correlation between the scores on the test and a predicted independent behaviour.

v) Discriminant: this aims to find correlations between different measures of the same behaviour (eg: test scores and observations of behaviour). Sophisticated

techniques like Multi-Trait Multi-Method (MTMM) (Campbell and Fiske 1959) also establish behaviours that should not go together.

Table 15 shows the most important aspects of reliability and validity in the diagnosis of Dependent Personality Disorder.

RELIABILITY	DEPENDENT PERSONALITY DISORDER
test-retest	same diagnosis or test score at two points in time
VALIDITY	
face/content	dependent behaviour seems logical to expect from Dependent Personality Disorder
construct	dependency is a theoretical personality construct and will be made up of behaviours, like the need for others to help, and difficulty making own decisions
convergent	two scores on different tests or two independent diagnoses
criterion	predicted independent behaviour eg: indecisiveness unless others help make decisions
discriminant	measures of Dependent Personality Disorder from a test correlated with diagnosis by an observer or interview
MTMM	expected behaviour - need others to make decisions / not expected - make own decisions
	- need others to care for them / - care for self
	- afraid of being alone / - happy to be alone

Table 15 - Reliability and validity and Dependent Personality Disorder.

12. For example, Personality Psychopathy (PSY-5) (Harkness and McNulty 1994) has an average test-retest reliability in 0.70s, but the limited studies on convergent and discriminant validity "suggest that certain scales may tap somewhat different constructs" (Clark and Harrison 2001 p293). Median test-retest reliability varies from 0.52 for Personality Diagnostic Questionnaire (PDQ-R) (Trull 1993) to 0.90 for Coolidge Axis II Inventory (CATI) (Coolidge and Merwin 1992) (Clark and Harrison 2001).

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